



General Assembly

**Substitute Bill No. 1116**

January Session, 2023



**AN ACT CONCERNING A STATE-OPERATED REINSURANCE PROGRAM AND HEALTH CARE COST GROWTH.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective from passage*) (a) For the purposes of this  
2 section:

3 (1) "Affordable Care Act" has the same meaning as provided in  
4 section 38a-1080 of the general statutes;

5 (2) "Exchange" means the Connecticut Health Insurance Exchange  
6 established under section 38a-1081 of the general statutes; and

7 (3) "Office" means the Office of Health Strategy established under  
8 section 19a-754a of the general statutes, as amended by this act.

9 (b) The office shall, in conjunction with the Office of Policy and  
10 Management, the Insurance Department and the Health Reinsurance  
11 Association created under section 38a-556 of the general statutes, seek a  
12 state innovation waiver under Section 1332 of the Affordable Care Act  
13 to establish a reinsurance program pursuant to subsection (d) of this  
14 section.

15 (c) Subject to the approval of a waiver described in subsection (b) of  
16 this section, the office, not later than September 1, 2024, for plan year

17 2025, and annually thereafter for the subsequent plan year, shall:

18 (1) Determine the amount needed, not to exceed twenty-one million  
19 two hundred ten thousand dollars, annually, to fund the reinsurance  
20 program established pursuant to subsection (d) of this section; and

21 (2) Inform the Office of Policy and Management of the amount  
22 determined pursuant to subdivision (1) of this subsection.

23 (d) The amount set forth in subsection (c) of this section shall be  
24 utilized to establish a reinsurance program for the individual health  
25 insurance market designed to lower premiums on health benefit plans  
26 sold in such market, on and off the exchange, provided the federal  
27 government approves the waiver described in subsection (b) of this  
28 section. Any such reinsurance program shall be administered by the  
29 Health Reinsurance Association. The Treasurer shall annually pay the  
30 amount as described in subsection (c) of this section for the purpose of  
31 administering such reinsurance program.

32 (e) If the waiver described in subsection (b) of this section terminates  
33 and the office does not obtain another waiver pursuant to subsection (a)  
34 of this section, the Treasurer shall cease paying the amount described in  
35 subsection (c) of this section for the purpose of administering the  
36 reinsurance program established pursuant to subsection (d) of this  
37 section.

38 Sec. 2. Subsection (b) of section 19a-754a of the general statutes is  
39 repealed and the following is substituted in lieu thereof (*Effective October*  
40 *1, 2023*):

41 (b) The Office of Health Strategy shall be responsible for the  
42 following:

43 (1) Developing and implementing a comprehensive and cohesive  
44 health care vision for the state, including, but not limited to, a  
45 coordinated state health care cost containment strategy;

46 (2) Promoting effective health planning and the provision of quality  
47 health care in the state in a manner that ensures access for all state  
48 residents to cost-effective health care services, avoids the duplication of  
49 such services and improves the availability and financial stability of  
50 such services throughout the state;

51 (3) Directing and overseeing the State Innovation Model Initiative  
52 and related successor initiatives;

53 (4) (A) Coordinating the state's health information technology  
54 initiatives, (B) seeking funding for and overseeing the planning,  
55 implementation and development of policies and procedures for the  
56 administration of the all-payer claims database program established  
57 under section 19a-775a, (C) establishing and maintaining a consumer  
58 health information Internet web site under section 19a-755b, and (D)  
59 designating an unclassified individual from the office to perform the  
60 duties of a health information technology officer as set forth in sections  
61 17b-59f and 17b-59g;

62 (5) Directing and overseeing the Health Systems Planning Unit  
63 established under section 19a-612 and all of its duties and  
64 responsibilities as set forth in chapter 368z;

65 (6) Convening forums and meetings with state government and  
66 external stakeholders, including, but not limited to, the Connecticut  
67 Health Insurance Exchange, to discuss health care issues designed to  
68 develop effective health care cost and quality strategies;

69 (7) Consulting with the Commissioner of Social Services, Insurance  
70 Commissioner and Connecticut Health Insurance Exchange on the  
71 Covered Connecticut program described in section 19a-754c; and

72 (8) (A) Setting an annual health care cost growth benchmark and  
73 primary care spending target pursuant to section 19a-754g, as amended  
74 by this act, (B) developing and adopting health care quality benchmarks  
75 pursuant to section 19a-754g, as amended by this act, (C) developing  
76 strategies, in consultation with stakeholders, to meet such benchmarks

77 and targets developed pursuant to section 19a-754g, as amended by this  
78 act, (D) enhancing the transparency of hospitals, as defined in section  
79 19a-490, (E) enhancing the transparency of provider entities, as defined  
80 in subdivision [(13)] (14) of section 19a-754f, as amended by this act, [(E)]  
81 (F) monitoring the development of accountable care organizations and  
82 patient-centered medical homes in the state, and [(F)] (G) monitoring  
83 the adoption of alternative payment methodologies in the state.

84 Sec. 3. Section 19a-754f of the general statutes is repealed and the  
85 following is substituted in lieu thereof (*Effective October 1, 2023*):

86 For the purposes of this section and sections 19a-754g to 19a-754k,  
87 inclusive, as amended by this act:

88 (1) "Drug manufacturer" means the manufacturer of a drug that is:  
89 (A) Included in the information and data submitted by a health carrier  
90 pursuant to section 38a-479qqq, (B) studied or listed pursuant to  
91 subsection (c) or (d) of section 19a-754b, or (C) in a therapeutic class of  
92 drugs that the executive director determines, through public or private  
93 reports, has had a substantial impact on prescription drug expenditures,  
94 net of rebates, as a percentage of total health care expenditures;

95 (2) "Executive director" means the executive director of the Office of  
96 Health Strategy;

97 (3) "Health care cost growth benchmark" means the annual  
98 benchmark established pursuant to section 19a-754g, as amended by  
99 this act;

100 (4) "Health care quality benchmark" means an annual benchmark  
101 established pursuant to section 19a-754g, as amended by this act;

102 (5) "Health care provider" has the same meaning as provided in  
103 subdivision (1) of subsection (a) of section 19a-17b;

104 (6) "Hospital" means any health care facility, as defined in section 19a-  
105 630, that is licensed as a short-term general hospital by the Department

106 of Public Health;

107 [(6)] (7) "Net cost of private health insurance" means the difference  
108 between premiums earned and benefits incurred, and includes insurers'  
109 costs of paying bills, advertising, sales commissions, and other  
110 administrative costs, net additions or subtractions from reserves, rate  
111 credits and dividends, premium taxes and profits or losses;

112 [(7)] (8) "Office" means the Office of Health Strategy established  
113 under section 19a-754a, as amended by this act;

114 [(8)] (9) "Other entity" means a drug manufacturer, pharmacy  
115 benefits manager or other health care provider that is not considered a  
116 provider entity;

117 [(9)] (10) "Payer" means a payer, including Medicaid, Medicare and  
118 governmental and nongovernment health plans, and includes any  
119 organization acting as payer that is a subsidiary, affiliate or business  
120 owned or controlled by a payer that, during a given calendar year, pays  
121 health care providers for health care services, hospitals or pharmacies  
122 or provider entities for prescription drugs designated by the executive  
123 director;

124 [(10)] (11) "Performance year" means the most recent calendar year  
125 for which data were submitted for the applicable health care cost growth  
126 benchmark, primary care spending target or health care quality  
127 benchmark;

128 [(11)] (12) "Pharmacy benefits manager" has the same meaning as  
129 provided in subdivision (10) of section 38a-479ooo;

130 [(12)] (13) "Primary care spending target" means the annual target  
131 established pursuant to section 19a-754g, as amended by this act;

132 [(13)] (14) "Provider entity" means an organized group of clinicians  
133 that come together for the purposes of contracting, or are an established  
134 billing unit that, at a minimum, includes primary care providers, and

135 that collectively, during any given calendar year, has enough attributed  
136 lives to participate in total cost of care contracts, even if they are not  
137 engaged in a total cost of care contract;

138 [(14)] (15) "Potential gross state product" means a forecasted measure  
139 of the economy that equals the sum of the (A) expected growth in  
140 national labor force productivity, (B) expected growth in the state's labor  
141 force, and (C) expected national inflation, minus the expected state  
142 population growth;

143 [(15)] (16) "Total health care expenditures" means the sum of all  
144 health care expenditures in this state from public and private sources  
145 for a given calendar year, including: (A) All claims-based spending paid  
146 to providers, net of pharmacy rebates, (B) all patient cost-sharing  
147 amounts, and (C) the net cost of private health insurance; and

148 [(16)] (17) "Total medical expense" means the total cost of care for the  
149 patient population of a payer or provider entity for a given calendar  
150 year, where cost is calculated for such year as the sum of (A) all claims-  
151 based spending paid to providers by public and private payers, and net  
152 of pharmacy rebates, (B) all nonclaims payments for such year,  
153 including, but not limited to, incentive payments and care coordination  
154 payments, and (C) all patient cost-sharing amounts expressed on a per  
155 capita basis for the patient population of a payer or provider entity in  
156 this state.

157 Sec. 4. Section 19a-754g of the general statutes is repealed and the  
158 following is substituted in lieu thereof (*Effective October 1, 2023*):

159 (a) Not later than July 1, 2022, the executive director shall publish (1)  
160 the health care cost growth benchmarks and annual primary care  
161 spending targets as a percentage of total medical expenses for the  
162 calendar years 2021 to 2025, inclusive, and (2) the annual health care  
163 quality benchmarks for the calendar years 2022 to 2025, inclusive, on the  
164 office's Internet web site.

165 (b) (1) (A) Not later than July 1, 2025, and every five years thereafter,

166 the executive director shall develop and adopt annual health care cost  
167 growth benchmarks and annual primary care spending targets for the  
168 succeeding five calendar years for hospitals, provider entities and  
169 payers.

170 (B) In developing the health care cost growth benchmarks and  
171 primary care spending targets pursuant to this subdivision, the  
172 executive director shall consider (i) any historical and forecasted  
173 changes in median income for individuals in the state and the growth  
174 rate of potential gross state product, (ii) the rate of inflation, and (iii) the  
175 most recent report prepared by the executive director pursuant to  
176 subsection (b) of section 19a-754h, as amended by this act.

177 (C) (i) The executive director shall hold at least one informational  
178 public hearing prior to adopting the health care cost growth benchmarks  
179 and primary care spending targets for each succeeding five-year period  
180 described in this subdivision. The executive director may hold  
181 informational public hearings concerning any annual health care cost  
182 growth benchmark and primary care spending target set pursuant to  
183 subsection (a) or subdivision (1) of subsection (b) of this section. Such  
184 informational public hearings shall be held at a time and place  
185 designated by the executive director in a notice prominently posted by  
186 the executive director on the office's Internet web site and in a form and  
187 manner prescribed by the executive director. The executive director  
188 shall make available on the office's Internet web site a summary of any  
189 such informational public hearing and include the executive director's  
190 recommendations, if any, to modify or not to modify any such annual  
191 benchmark or target.

192 (ii) If the executive director determines, after any informational  
193 public hearing held pursuant to this subparagraph, that a modification  
194 to any health care cost growth benchmark or annual primary care  
195 spending target is, in the executive director's discretion, reasonably  
196 warranted, the executive director may modify such benchmark or  
197 target.

198 (iii) The executive director shall annually (I) review the current and  
199 projected rate of inflation, and (II) include on the office's Internet web  
200 site the executive director's findings of such review, including the  
201 reasons for making or not making a modification to any applicable  
202 health care cost growth benchmark. If the executive director determines  
203 that the rate of inflation requires modification of any health care cost  
204 growth benchmark adopted under this section, the executive director  
205 may modify such benchmark. In such event, the executive director shall  
206 not be required to hold an informational public hearing concerning such  
207 modified health care cost growth benchmark.

208 (D) The executive director shall post each adopted health care cost  
209 growth benchmark and annual primary care spending target on the  
210 office's Internet web site.

211 (E) Notwithstanding the provisions of subparagraphs (A) to (D),  
212 inclusive, of this subdivision, if the average annual health care cost  
213 growth benchmark for a succeeding five-year period described in this  
214 subdivision differs from the average annual health care cost growth  
215 benchmark for the five-year period preceding such succeeding five-year  
216 period by more than one-half of one per cent, the executive director shall  
217 submit the annual health care cost growth benchmarks developed for  
218 such succeeding five-year period to the joint standing committee of the  
219 General Assembly having cognizance of matters relating to insurance  
220 for the committee's review and approval. The committee shall be  
221 deemed to have approved such annual health care cost growth  
222 benchmarks for such succeeding five-year period, except upon a vote to  
223 reject such benchmarks by the majority of committee members at a  
224 meeting of such committee called for the purpose of reviewing such  
225 benchmarks and held not later than thirty days after the executive  
226 director submitted such benchmarks to such committee. If the  
227 committee votes to reject such benchmarks, the executive director may  
228 submit to the committee modified annual health care cost growth  
229 benchmarks for such succeeding five-year period for the committee's  
230 review and approval in accordance with the provisions of this

231 subparagraph. The executive director shall not be required to hold an  
232 informational public hearing concerning such modified benchmarks.  
233 Until the joint standing committee of the General Assembly having  
234 cognizance of matters relating to insurance approves annual health care  
235 cost growth benchmarks for the succeeding five-year period, such  
236 benchmarks shall be deemed to be equal to the average annual health  
237 care cost growth benchmark for the preceding five-year period.

238 (2) (A) Not later than July 1, 2025, and every five years thereafter, the  
239 executive director shall develop and adopt annual health care quality  
240 benchmarks for the succeeding five calendar years for hospitals,  
241 provider entities and payers.

242 (B) In developing annual health care quality benchmarks pursuant to  
243 this subdivision, the executive director shall consider (i) quality  
244 measures endorsed by nationally recognized organizations, including,  
245 but not limited to, the National Quality Forum, the National Committee  
246 for Quality Assurance, the Centers for Medicare and Medicaid Services,  
247 the Centers for Disease Control, the Joint Commission and expert  
248 organizations that develop health equity measures, and (ii) measures  
249 that: (I) Concern health outcomes, overutilization, underutilization and  
250 patient safety, (II) meet standards of patient-centeredness and ensure  
251 consideration of differences in preferences and clinical characteristics  
252 within patient subpopulations, and (III) concern community health or  
253 population health.

254 (C) (i) The executive director shall hold at least one informational  
255 public hearing prior to adopting the health care quality benchmarks for  
256 each succeeding five-year period described in this subdivision. The  
257 executive director may hold informational public hearings concerning  
258 the quality measures the executive director proposes to adopt as health  
259 care quality benchmarks. Such informational public hearings shall be  
260 held at a time and place designated by the executive director in a notice  
261 prominently posted by the executive director on the office's Internet  
262 web site and in a form and manner prescribed by the executive director.  
263 The executive director shall make available on the office's Internet web

264 site a summary of any such informational public hearing and include  
265 the executive director's recommendations, if any, to modify or not  
266 modify any such health care quality benchmark.

267 (ii) If the executive director determines, after any informational  
268 public hearing held pursuant to this subparagraph, that modifications  
269 to any health care quality benchmarks are, in the executive director's  
270 discretion, reasonably warranted, the executive director may modify  
271 such quality benchmarks. The executive director shall not be required  
272 to hold an additional informational public hearing concerning such  
273 modified quality benchmarks.

274 (D) The executive director shall post each adopted health care quality  
275 benchmark on the office's Internet web site.

276 (c) The executive director may enter into such contractual agreements  
277 as may be necessary to carry out the purposes of this section, including,  
278 but not limited to, contractual agreements with actuarial, economic and  
279 other experts and consultants. The executive director or the executive  
280 director's contractors, in carrying out the purposes of this section and  
281 sections 19a-754f, as amended by this act, and 19a-754h to 19a754j,  
282 inclusive, as amended by this act, shall utilize currently available data  
283 sources, including data available through the all-payer claims database  
284 established under section 19a-755a.

285 Sec. 5. Section 19a-754h of the general statutes is repealed and the  
286 following is substituted in lieu thereof (*Effective from passage*):

287 (a) Not later than August 15, 2022, and annually thereafter, each  
288 payer shall report to the executive director, in a form and manner  
289 prescribed by the executive director, for the preceding or prior years, if  
290 the executive director so requests based on material changes to data  
291 previously submitted, aggregated data, including aggregated self-  
292 funded data as applicable, necessary for the executive director to  
293 calculate total health care expenditures, primary care spending as a  
294 percentage of total medical expenses and net cost of private health

295 insurance. Each payer shall also disclose, as requested by the executive  
296 director, payer data required for adjusting total medical expense  
297 calculations to reflect changes in the patient population.

298 (b) Not later than March 31, 2023, and annually thereafter, the  
299 executive director shall prepare and post on the office's Internet web  
300 site, a report concerning the total health care expenditures utilizing the  
301 total aggregate medical expenses reported by payers pursuant to  
302 subsection (a) of this section, including, but not limited to, a breakdown  
303 of such population-adjusted total medical expenses by payer, hospital  
304 and provider entities. The report may include, but shall not be limited  
305 to, information regarding the following:

306 (1) Trends in major service category spending;

307 (2) Primary care spending as a percentage of total medical expenses;

308 (3) The net cost of private health insurance by payer by market  
309 segment, including individual, small group, large group, self-insured,  
310 student and Medicare Advantage markets; and

311 (4) Any other factors the executive director deems relevant to  
312 providing context on such data, which shall include, but not be limited  
313 to, the following factors: (A) The impact of the rate of inflation and rate  
314 of medical inflation; (B) impacts, if any, on access to care; and (C)  
315 responses to public health crises or similar emergencies.

316 (c) The executive director shall annually submit a request to the  
317 federal Centers for Medicare and Medicaid Services for the unadjusted  
318 total medical expenses of Connecticut residents.

319 (d) Not later than August 15, 2023, and annually thereafter, each  
320 payer, hospital or provider entity shall report to the executive director  
321 in a form and manner prescribed by the executive director, for the  
322 preceding year, and for prior years if the executive director so requests  
323 based on material changes to data previously submitted, on the health  
324 care quality benchmarks adopted pursuant to section 19a-754g, as

325 amended by this act.

326 (e) Not later than March 31, 2024, and annually thereafter, the  
327 executive director shall prepare and post on the office's Internet web  
328 site, a report concerning health care quality benchmarks reported by  
329 payers, hospitals and provider entities pursuant to subsection (d) of this  
330 section.

331 (f) The executive director may enter into such contractual agreements  
332 as may be necessary to carry out the purposes of this section, including,  
333 but not limited to, contractual agreements with actuarial, economic and  
334 other experts and consultants.

335 Sec. 6. Subsection (a) of section 19a-754i of the general statutes is  
336 repealed and the following is substituted in lieu thereof (*Effective October*  
337 *1, 2023*):

338 (a) (1) For each calendar year, beginning on January 1, 2023, the  
339 executive director shall, if the payer, hospital or provider entity subject  
340 to the cost growth benchmark or primary care spending target so  
341 requests, meet with such payer, hospital or provider entity to review  
342 and validate the total medical expenses data collected pursuant to  
343 section 19a-754h, as amended by this act, for such payer, hospital or  
344 provider entity. The executive director shall review information  
345 provided by the payer, hospital or provider entity and, if deemed  
346 necessary, amend findings for such payer, hospital or provider prior to  
347 the identification of payer, hospital or provider entities that exceeded  
348 the health care cost growth benchmark or failed to meet the primary care  
349 spending target for the performance year as set forth in section 19a-754h,  
350 as amended by this act. The executive director shall identify, not later  
351 than May first of such calendar year, each payer, hospital or provider  
352 entity that exceeded the health care cost growth benchmark or failed to  
353 meet the primary care spending target for the performance year.

354 (2) For each calendar year beginning on or after January 1, 2024, the  
355 executive director shall, if the payer, hospital or provider entity subject

356 to the health care quality benchmarks for the performance year so  
357 requests, meet with such payer, hospital or provider entity to review  
358 and validate the quality data collected pursuant to section 19a-754h, as  
359 amended by this act, for such payer, hospital or provider entity. The  
360 executive director shall review information provided by the payer,  
361 hospital or provider entity and, if deemed necessary, amend findings  
362 for such payer, hospital or provider prior to the identification of payer,  
363 hospital or provider entities that exceeded the health care quality  
364 benchmark as set forth in section 19a-754h, as amended by this act. The  
365 executive director shall identify, not later than May first of such calendar  
366 year, each payer, hospital or provider entity that exceeded the health  
367 care quality benchmark for the performance year.

368 (3) Not later than thirty days after the executive director identifies  
369 each payer, hospital or provider entity pursuant to subdivisions (1) and  
370 (2) of this subsection, the executive director shall send a notice to each  
371 such payer, hospital or provider entity. Such notice shall be in a form  
372 and manner prescribed by the executive director, and shall disclose to  
373 each such payer, hospital or provider entity:

374 (A) That the executive director has identified such payer, hospital or  
375 provider entity pursuant to subdivision (1) or (2) of this subsection; and

376 (B) The factual basis for the executive director's identification of such  
377 payer, hospital or provider entity pursuant to subdivision (1) or (2) of  
378 this subsection.

379 Sec. 7. Section 19a-754j of the general statutes is repealed and the  
380 following is substituted in lieu thereof (*Effective October 1, 2023*):

381 (a) (1) Not later than June 30, 2023, and annually thereafter, the  
382 executive director shall hold an informational public hearing to  
383 compare the growth in total health care expenditures in the performance  
384 year to the health care cost growth benchmark established pursuant to  
385 section 19a-754g, as amended by this act, for such year. Such hearing  
386 shall involve an examination of:

387 (A) The report most recently prepared by the executive director  
388 pursuant to subsection (b) of section 19a-754h, as amended by this act;

389 (B) The expenditures of hospitals, provider entities and payers,  
390 including, but not limited to, health care cost trends, primary care  
391 spending as a percentage of total medical expenses and the factors  
392 contributing to such costs and expenditures; and

393 (C) Any other matters that the executive director, in the executive  
394 director's discretion, deems relevant for the purposes of this section.

395 (2) The executive director may require any payer, hospital or  
396 provider entity that, for the performance year, is found to be a  
397 significant contributor to health care cost growth in the state or has  
398 failed to meet the primary care spending target, to participate in such  
399 hearing. Each such payer, hospital or provider entity that is required to  
400 participate in such hearing shall provide testimony on issues identified  
401 by the executive director and provide additional information on actions  
402 taken to reduce such payer's, hospital's or entity's contribution to future  
403 state-wide health care costs and expenditures or to increase such  
404 payer's, hospital's or provider entity's primary care spending as a  
405 percentage of total medical expenses.

406 (3) The executive director may require that any other entity that is  
407 found to be a significant contributor to health care cost growth in this  
408 state during the performance year participate in such hearing. Any other  
409 entity that is required to participate in such hearing shall provide  
410 testimony on issues identified by the executive director and provide  
411 additional information on actions taken to reduce such other entity's  
412 contribution to future state-wide health care costs. If such other entity is  
413 a drug manufacturer, and the executive director requires that such drug  
414 manufacturer participate in such hearing with respect to a specific drug  
415 or class of drugs, such hearing may, to the extent possible, include  
416 representatives from at least one brand-name manufacturer, one generic  
417 manufacturer and one innovator company that is less than ten years old.

418 (4) Not later than October 15, 2023, and annually thereafter, the  
419 executive director shall prepare and submit a report, in accordance with  
420 section 11-4a, to the joint standing committees of the General Assembly  
421 having cognizance of matters relating to insurance and public health.  
422 Such report shall be based on the executive director's analysis of the  
423 information submitted during the most recent informational public  
424 hearing conducted pursuant to this subsection and any other  
425 information that the executive director, in the executive director's  
426 discretion, deems relevant for the purposes of this section, and shall:

427 (A) Describe health care spending trends in this state, including, but  
428 not limited to, trends in primary care spending as a percentage of total  
429 medical expense, and the factors underlying such trends;

430 (B) Include the findings from the report prepared pursuant to  
431 subsection (b) of section 19a-754h, as amended by this act;

432 (C) Describe a plan for monitoring any unintended adverse  
433 consequences, including, but not limited to, any impacts on funding for  
434 individuals with developmental disabilities, resulting from the  
435 adoption of cost growth benchmarks and primary care spending targets  
436 and the results of any findings from the implementation of such plan;  
437 and

438 (D) Disclose the executive director's recommendations, if any,  
439 concerning strategies to increase the efficiency of the state's health care  
440 system, including, but not limited to, any recommended legislation  
441 concerning the state's health care system.

442 (b) (1) Not later than June 30, 2024, and annually thereafter, the  
443 executive director shall hold an informational public hearing to  
444 compare the performance of payers, hospitals and provider entities in  
445 the performance year to the quality benchmarks established for such  
446 year pursuant to section 19a-754g, as amended by this act. Such hearing  
447 shall include an examination of:

448 (A) The report most recently prepared by the executive director

449 pursuant to subsection (e) of section 19a-754h, as amended by this act;  
450 and

451 (B) Any other matters that the executive director, in the executive  
452 director's discretion, deems relevant for the purposes of this section.

453 (2) The executive director may require any payer, hospital or  
454 provider entity that failed to meet any health care quality benchmarks  
455 in this state during the performance year to participate in such hearing.  
456 Each such payer, hospital or provider entity that is required to  
457 participate in such hearing shall provide testimony on issues identified  
458 by the executive director and provide additional information on actions  
459 taken to improve such payer's, hospital's or provider entity's quality  
460 benchmark performance.

461 (3) Not later than October 15, 2024, and annually thereafter, the  
462 executive director shall prepare and submit a report, in accordance with  
463 section 11-4a, to the joint standing committees of the General Assembly  
464 having cognizance of matters relating to insurance and public health.  
465 Such report shall be based on the executive director's analysis of the  
466 information submitted during the most recent informational public  
467 hearing conducted pursuant to this subsection and any other  
468 information that the executive director, in the executive director's  
469 discretion, deems relevant for the purposes of this section, and shall:

470 (A) Describe health care quality trends in this state and the factors  
471 underlying such trends;

472 (B) Include the findings from the report prepared pursuant to  
473 subsection (e) of section 19a-754h, as amended by this act; and

474 (C) Disclose the executive director's recommendations, if any,  
475 concerning strategies to improve the quality of the state's health care  
476 system, including, but not limited to, any recommended legislation  
477 concerning the state's health care system.

478 Sec. 8. (NEW) (*Effective October 1, 2023*) (a) For the purposes of this

479 section:

480 (1) "Campus" and "hospital-based facility" have the same meanings  
481 as provided in section 19a-508c of the general statutes; and

482 (2) "National provider identifier" means a standard, unique health  
483 identifier for each health care provider issued by the Centers for  
484 Medicare and Medicaid Services' National Plan and Provider  
485 Enumeration System.

486 (b) On and after January 1, 2024, each hospital-based facility in this  
487 state located off-site from a hospital campus shall submit with each  
488 claim for reimbursement or payment for health care services provided  
489 at such facility, such facility's national provider identifier and federal  
490 tax identification number. Such national provider identifier and federal  
491 tax identification number shall be (1) separate from any national  
492 provider identifier and federal tax identification number issued to such  
493 hospital campus, and (2) included on any claim for reimbursement or  
494 payment for health care services provided at such facility, regardless of  
495 whether such claim or reimbursement is filed or submitted by or  
496 through a separate facility or hospital.

497 (c) The Insurance Commissioner may adopt regulations, in  
498 accordance with the provisions of chapter 54 of the general statutes, to  
499 implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section
Sec. 2	<i>October 1, 2023</i>	19a-754a(b)
Sec. 3	<i>October 1, 2023</i>	19a-754f
Sec. 4	<i>October 1, 2023</i>	19a-754g
Sec. 5	<i>from passage</i>	19a-754h
Sec. 6	<i>October 1, 2023</i>	19a-754i(a)
Sec. 7	<i>October 1, 2023</i>	19a-754j
Sec. 8	<i>October 1, 2023</i>	New section

**INS**      *Joint Favorable Subst.*

**APP**      *Joint Favorable*